California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

REQUIREMENTS FOR FILING A CLINIC PERMIT APPLICATION

IMPORTANT: Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. If the number of forms provided is not sufficient, please make photocopies. You will be notified of any major deficiencies in your application. Please allow approximately 60 days from the time your application packet is complete before calling the Board of Pharmacy.

Any forms that have been previously submitted with another application will not be pulled from the file. You must complete and submit all of the requested information.

If you would like notification that the board has received your application, please submit a stamped postcard addressed to yourself.

SUMMARY OF CHECKLIST

Section A	Requirements for all applicants except government owned, Indian tribe owned, or change of location. Government owned entities see Section F. Indian tribe owned clinic, see Section G. Non-Indian owned but operating on tribal lands see Section H. For a change of location, see Section I.
Section B	Forms required for an applicant who is filing as an individual owner
Section C	Forms required for an applicant whose ownership is a partnership
Section D	Forms required for an applicant who is filing as a corporation
Section E	Forms required for an applicant who is filing as a limited liability company
Section F	Requirements for state, city or county owned clinic
Section G	Requirements for Indian tribe owned clinic
Section H	Requirements for non-Indian owned but operating on tribal lands
Section I	Requirements for change of location only (no ownership change)

CHECKLIST FOR FILING A CLINIC PERMIT APPLICATION

Section A All Applicants

[ ] 1. Application (17A-42) and the non-refundable processing fee of $340.

[ ] 2. A copy of the last Statement of Deficiencies and Plan of Correction (Form 2567) issued by the Department of Health Services, **or** if designated as an affiliate clinic by the Department of Health Services, a written statement on company letterhead indicating an inspection was not required.

[ ] 3. A copy of your Department of Health Services license.

[ ] 4. On company letterhead written certification that policies and procedures are in place.

[ ] 5. If Medicare certified, a current copy of the certification.

[ ] 6. Seller's Certification for a Pharmacy (17A-8) (If applicable)
This is only required for an application for a change of ownership and it must be submitted by the prospective owner(s).

Section B Individual Owner

[ ] 1. Certification of Personnel (17A-11) for the:

- Medical Director
- Administrator
- Consulting Pharmacist

[ ] 2. Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid for: Please refer to fingerprint instructions on page 6.

- Medical Director
- Administrator

Section C Partnership

[ ] 1. A copy of the partnership agreement.

[ ] 2. Certification of Personnel (17A-11) for the:

- Medical Director
- Administrator
- Consulting Pharmacist

[ ] 3. Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid for: Please refer to fingerprint instructions on page 6.

- Medical Director
- Administrator

Section D Corporation

[ ] 1. Articles of Incorporation **endorsed** by the Secretary of State.

[ ] 2. Certification of Personnel (17A-11) for the:

- Medical Director
- Administrator
- Consulting Pharmacist

[ ] 3. Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid for: Please refer to fingerprint instructions on page 6.

- Medical Director
- Administrator

Section E Limited Liability Company

[ ] 1. Articles of Organization **endorsed** by the Secretary of State.

[ ] 2. Certification of Personnel (17A-11) for the:

- Medical Director
- Administrator
- Consulting Pharmacist

[ ] 3. Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid for: Please refer to fingerprint instructions on page 6.

- Medical Director
- Administrator

Section F State, City, or County Owned Clinic

[ ] 1. Application (17A-42)

[ ] 2. Completed Certification of Personnel (17A-11) for:

a. Medical Director
b. Administrator
c. Consulting Pharmacist

[ ] 3. A letter of verification from the county public health department or the board of supervisors indicating that the facility is government owned

[ ] 4. The name of the Director of Public Health or the responsible party for the clinic operation

[ ] 5. A copy of the organizational structure

Section G Indian Owned

[ ] 1. Application (17A-42) and the non-refundable processing fee of $340.

[ ] 2. Official documents from the U.S. Department of Interior, Bureau of Indian Affairs, identifying the official tribe.

[ ] 3. A copy of the constitution and by-laws establishing the tribal council that will be the governing entity of the clinic.

[ ] 4. Certification of Personnel (17A-11) for the tribal council members and the administrator/CEO.

[ ] 5. Certification of Personnel (17A-11) for the consulting pharmacist.

[ ] 6. Copy of *Request for Live Scan Service Form* verifying fingerprints for the tribal council and the administrator/CEO have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 6.

Section H Non-Indian owned but operating on tribal lands

If the non-Indian owner is a corporation:

[ ] 1. All requirements listed in Section A.

[ ] 2. Articles of incorporation endorsed by the Indian tribe.

[ ] 3. Statement by domestic stock endorsed by the Indian tribe.

[ ] 4. **AND all other requirements** of corporate owners listed in section D, (except the articles of incorporation and the statement by domestic stock must be endorsed by the Indian tribe and not by the Secretary of State).

If the non-Indian owner is a sole owner or partnership:

[ ] 1. All requirements listed in Section A.

[ ] 2. Documents describing the agreements with the Indian tribe to operate the clinic on tribal land.

[ ] 3. **AND all other requirements** of sole owners or partnership listed in Section B or Section C respectively.

Section I Change of Location ONLY (no ownership change)

[ ] 1. Application (17A-42) and the non-refundable processing fee of $60.

[ ] 2. Certification of Personnel (17A-11) for the:

- Medical Director
- Administrator
- Consulting Pharmacist

[ ] 3. A copy of the last Statement of Deficiencies and Plan of Correction (Form 2567) issued by the Department of Health Services.

[ ] 4. A copy of your Department of Health Services license.

[ ] 5. On company letterhead, written certification that policies and procedures are in place, pursuant to section 4181 of the Business & Professions Code.

[ ] 6. If Medicare certified, a current copy of the certification.

** Effective January 1, 2001, the Board of Pharmacy requires all applicants for a new license to have not only a California Department of Justice (DOJ) criminal record check but also a federal background check. **No license will be issued without background clearances from both agencies.**

Fingerprint Requirements

California Residents

The board will only accept Live Scan Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at http://caag.state.ca.us/app/contact.pdf or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of $66 ($32 California Department of Justice (DOJ) fee, $10 DOJ expedite fee and $24 FBI fingerprint processing fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

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CLINIC PERMIT APPLICATION

Please print or type **All blanks must be completed. If not applicable enter N/A**

Name of Clinic:	Clinic telephone number:
Address of Clinic: Number and street City State Zip Code	
Type of Clinic: ☐ Free ☐ Multi-Specialty ☐ Community ☐ Non Profit ☐ Profit ☐ Other ☐ Surgical ☐ Ambulatory Surgical	
Indicate whether this application is for: ☐ New Clinic ☐ Change of Location ☐ Change of Ownership	
If change of ownership or change of location, indicate previous name, address and license number of clinic:	
Type of ownership: ☐ Individual ☐ Partnership ☐ Corporation ☐ Government ☐ Limited Liability Company	
Date of last inspection by the Department of Health Services:	Are you Medicare Certified? If yes, attach a copy of your current medicare certificate. ☐ Yes ☐ No
Anticipated first day of business:	
Mail all correspondence to the following address below. If correspondence should be mailed to the clinic please insert "Same as Clinic."	
Name and telephone number of contact person to clarify information provided on this application. ( )	e-mail address

Continue on reverse

For Office Use Only			
Staff Review			Cashier
☐ Articles of Inc ☐ Partner Agreement ☐ Seller's Cert ☐ DHS Insp Report	☐ DHS license ☐ Policy & Proc ☐ Medicare cert	Approval_____ Denied_____ Date_____	Cashiering #_____ Date_____ Amount of Fee_____
Date referred:			

Ownership Information

Name of Sole Owner (If applicable)			*Social Security Number		Telephone Number
Address	number and street	City		State	Zip Code
Name of Partner (If applicable)			*FEIN Number		Telephone Number
Address	number and street	City		State	Zip Code
Name of Partner (If applicable)			*FEIN Number		Telephone Number
Address	number and street	City		State	Zip Code
Name of Corporation (If applicable)					Telephone Number
Address	number and street	City		State	Zip Code

Print below the name, title, address and license number of all the clinic owners. This includes the individual owner, all partners, corporate officers. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian etc., and license number. Non-profit organizations must list the names and titles of persons holding corporate positions. Attach additional sheet if necessary.

Title	Name	Residence Address	Licensed as and license number

*Disclosure of your U.S. social security account number, or federal employer identification number (FEIN) if you are a partnership, is mandatory. Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC 405(c)(2)(C)) authorize collection of your social security account number. Your social security account number or FEIN will be used exclusively for tax enforcement purposes, or for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code. If you fail to disclose your social security account number or your FEIN, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

FEDERAL EMPLOYEE ID NUMBER (FEIN): | | | | | | | | | |

Name of Professional Director:			License Number
Residence Address	City	State	Zip Code
Name of Administrator:			License Number
Residence Address	City	State	Zip Code
Name of Consulting pharmacist:			License Number
Residence Address	City	State	Zip Code

I certify that the policies and procedures of the clinic's drug distribution service are consistent with the promotion and protection of health and safety of the public regarding inventories, security, training, protocol development, recordkeeping, packaging, labeling dispensing, and patient consultation.

Signature of Consulting Pharmacist	Name (please print)	Date

PLEASE READ CAREFULLY

This application must be approved by the California State Board of Pharmacy before a clinic permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) the clinic complies with all applicable laws and regulations of the State Department of Health Services relating to drug distribution (Title 22, Article 4); (5) the professional director is responsible for safe, orderly and lawful provisions of the pharmacy service; (6) all supplemental statements are true and accurate. I am also aware that I am bound by the applicable Federal and State laws and regulations pertaining to the practice of pharmacy; and (7) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

Signature of Professional Director	Name (please print)	Title	Date
Signature of Administrator	Name (please print)	Title	Date
Signature of Corporate officer, owner, or partner	Name (please print)	Title	Date
Signature of Corporate officer, owner, or partner	Name (please print)	Title	Date

17A-42 (Rev. 6/04)

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SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted by the prospective owner with the application for a change of ownership. Attach a copy of the pending purchase agreement.

NOTICE: The current permit is not transferable and the current owner of record must maintain operations and control of the licensed premises (including renewing the permit) until a new application is approved by the Board of Pharmacy. The new owner must complete and attach the new application to this document. (Proof of authority to sell by any person, except a person whose name appears on the original permit, must accompany this certification.)

(Please print or type) **All blanks must be completed; if not applicable enter N/A**

This will certify that _____
(name of individual, partnership* or corporation – "seller")

has agreed that on _____ "seller" shall transfer _____
month/day/year (all, half, etc.)

of the right, title and interest in _____ _____
(name of premises) (permit number)

located at _____
(street number and name) (city) (state) (zip code)

To _____
(name of buyer(s))

*IF A PARTNERSHIP, LIST THE NAMES OF ALL PARTNERS (all names must be listed)

On completion of this sale and approval of the new permit, the original permit, and the current renewal must be returned to the California State Board of Pharmacy for cancellation, before the new permit will be released.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that: (1) he/she is the licensee, general partner or an executive officer of the corporate licensee named in this Seller's Certification, duly authorized to make this sale; and (2) all statements made in this Seller's Certification are true and correct to the best of his/her knowledge. If the seller is a partnership, all partners must sign below.

Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date

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CERTIFICATION OF PERSONNEL

INSTRUCTIONS: **Must be completed by each owner, director, officer, major shareholder and pharmacist-in-charge.** All blanks must be completed; if not applicable, enter N/A. Failure to furnish a complete explanation or any omissions **will delay** the processing of your application.

1. Full name (last, first, middle)	
2. Residence address (street, city, state, zip code)	Residence telephone number ( )

3. Are you currently licensed as a physician, podiatrist, dentist, optometrist or veterinarian in this state or any other state? If the answer is "yes," please list each license number, license type, and the state(s) where you are licensed. ☐ Yes ☐ No

License Type	License Number	State	Expiration Date

4. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest, licensed in this state or any other state, as a physician, podiatrist, dentist, or veterinarian? If the answer is "yes," list the name of each person, their relationship to you, the license type, number and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name	Relationship	License Type	License Number	State

5. Are you currently, or have you previously been, listed as a corporate officer, partner, owner, manager, limited liability company member, administrator or medical director on a permit to sell, store or possess dangerous drugs or dangerous devices in this state or any other state? If "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include information regarding cancelled permits. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of company	Type of permit	Permit number	Position held	State	Expiration date

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes," please provide permit type, action, company name (if applicable), year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

7. Are you currently, or have you previously been, associated in business with any person, partnership, corporation, or other entity, or shared a financial or community property interest with any person whose pharmacy permit, or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken, by this or any other governmental authority in this state or any other state? If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

8. Have you ever been in violation of any provisions of pharmacy law, in this or any other state? If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

9. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States, any state or local jurisdiction? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside and/or dismissed under Penal Code section 1000 or 1203.4. (Traffic violations of $500 or less need not be reported.) If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the complete penalty received. ☐ Yes ☐ No

10. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks? ☐ Yes ☐ No

If “yes,” attach a statement of explanation. If “no,” go directly to question 12.

11. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? ☐ Yes ☐ No
If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

12. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances? ☐ Yes ☐ No
If " yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to ensure that you are not engaging in the illegal use of controlled substances? **Please attach a statement of explanation.**

13. Will you work as an employee of this business? If yes, what will your responsibilities and duties be with this business? ☐ Yes ☐ No

_____

You must provide a written explanation for all affirmative answers to questions 3 - 12. Failure to do so may result in this application being deemed withdrawn as incomplete.

If you are a non-pharmacist owner, partner, corporate officer, corporate director or administrator of the business, you should be aware that:

(a) any non-pharmacist owner who commits any act which would subvert or tends to subvert the efforts of the pharmacist-in-charge to comply with the laws governing the operation of the pharmacy is guilty of a misdemeanor;

(b) you may not order a pharmacist to perform any act which is prohibited by law;

(c) any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying;

(d) committing any act prohibited by law, or neglecting to perform any duty required by law, could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.

(e) you are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties which are required by law or regulation to be done by a pharmacist;

(f) only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy;

(g) you may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714);

(h) dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold on prescription or to persons who are licensed to handle, sell and possess such drugs.

All items of information requested on this form are mandatory. Failure to provide any of the requested information will result in the application being deemed withdrawn as incomplete. This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the executive officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing certification of personnel form, including all supplementary statements ,and I personally completed this certification of personnel form.

I also certify that I have read and understand the rules of professional conduct and have retained a copy on file.

_____ _____

Signature Date

INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://caag.state.ca.us/app/contact.pdf or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of $32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Clinic - Section 4201

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Clinic - Section 4201

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Clinic - Section 4201

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed